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OCT 3 1 2011

Application for License to Operate a Long-term Care Facility

For Office Use Only Received M/31/11
Amount /400.00

OFFICE OF INSPECTOR GENERAL

1.	IDENTIFICATION			
	Name <u>Geo</u>	Rgetown Manor		
	Address <u>Goo</u>	Gageh Ave		
	City/County/Zip	uisville, Ky 402	16	
	Telephone number 502-368-5827 Hell.gm@insightbbicon			
	Administrator <u>*</u>	Raymond Bell		
	Date facility operation be	9		
	Date facility began opera	ation under current owner _/9	70	
II.	TYPE BEDS	No. beds licensed	No. beds requested	
	Skilled			
	Nursing Home			
	Nursing Facility	120	_/20	
	Intermediate Care			
	ICF/MR			
	Personal Care		\$4+0x40x40x1xxxxxxxxxxxxxxxxxxxxxxxxxxxxx	
II.	CONTROL (check one in each column)			
	State County City Private	Profit Nonprofit	Individual Partnership Corporation	
II.	OWNERSHIP			
	partners.	dividual owner, partners or corpo Foundation / Kentucky ce Dr Suite 100 43017	•	

If facility owned or leased by a corpo	If facility owned or leased by a corporation, complete the following:		
Name of corporation AHF/Kedf	Name of corporation AHF/Kentucky - Town, Inc		
Address of corporation <u>5920 Ve</u>	Address of corporation 5920 Venture Dr Suite 100 Dublin OH 430V		
President or Chairman ShN	President or Chairman John Haemmerle		
Vice President <u>Mark</u>	Haemmerle		
Secretary M.Ke	Haemmerle		
Treasurer <u>Mark</u>	Haemmerle		
,	Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility. If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation. If owned by a partnership, attach a separate sheet listing the names and addresses of each partner. Name and address of parent corporation and/or management company, if applicable.		
Name and address of parent corpora			
Parent	Management Company AHF Management Corp. 5920 Venture Dr Ste 100 Dublin, OH 43017		
to the Office of Inspector General and a ne that this facility and all aspects of its ope surveillance by all state agency licensure	ation that affects my licensure status will be reported we application will be completed at that time. I agree wration shall be open at all times to inspection and personnel. I certify that the information given in the best of my knowledge and recognize that denial or revocation of licensure. Administrator Title Date		
oturn Application and fee to: Office of Inspector General 275 East Main Street, 5E-A Frankfort, Kentucky 40621			

OIG 5 (10/2002)